NORTH DAKOTA MEDICAID

PROVIDER BULLETIN

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IN THIS ISSUE

MEDICAL SERVICES DIVISION

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DEFICIT REDUCTION ACT OF 2005

The Deficit Reduction (DRA) Act of 2005, signed into law by President Bush on February 8, 2006 requires all entities that make or receive at least $5 million in annual Medicaid payments to establish specific written policies and procedures to inform employees about certain federal and state false claims and whistleblower laws beginning January 1, 2007.

(1) *Affected Entities.* The new requirements apply to any entity that receives or makes annual payments of at least $5 million under a state Medicaid plan.

(2) *Written Policies and Procedures.* The DRA requires written policies and procedures. Training is not specifically required, but the provisions contemplate that entities dealing with state Medicaid programs will inform their employees of their policies.

(3) *Who to Inform.* The policies and procedures must inform all employees, including management, and anyone who could be considered a contractor or agent of the entity.

(4) *Content of the Policies and Procedures.* The polices and procedures must provide information on the following laws, including the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs:
   a. The federal False Claims Act;
   b. Federal administrative remedies for false claims and statements;
   c. State laws pertaining to civil or criminal penalties for false claims and statements; and
   d. Whistleblower provisions under the federal and state laws.

(5) *Describe the Entity's Policies and Procedures.* The polices and procedures must also provide details regarding the entity's policies and procedures for protecting fraud, waste, and abuse.

(6) *Employee Handbook*. The entity must include in its employee handbook:
   a. The specific discussion of applicable fraud and abuse laws,
   b. The rights of employees who are whistleblowers to be protected from retaliation, and
   c. The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

The Department has not received specific implementation guidance from the Centers for Medicare and Medicaid Services (CMS); however, health care providers and any other entities that make or receive Medicaid payments exceeding $5 million per year should review relevant procedures now to determine if any changes need to be made. The Department will distribute specific requirements, once guidance is received from CMS.

CLAIMS

Resubmitting Claims

When resubmitting a claim, the Internal Control Number (1006xxxxxxxxx) and Remittance Advice Date are required in box 22 on the HCFA claim form and box 84 on the UB claim form.

Timely Filing Limit For Claims

New Claims: Providers have one year from the date of service to submit new claims.

Processed Claims: Providers have one year from the last Remittance Advice date to resubmit or adjust claims.

Medicare Primary Claims Crossing To Medicaid

For crossover claims from Medicare that you have had no response from Medicaid: please wait 60 days from the Medicare EOB date before submitting a paper claim with the EOB attached for claims that state on the Medicare EOB that they have crossed to Medicaid. Although it states on the Medicare EOB the claims crossed to Medicaid, the actual transaction can take 60 – 90 days. If Medicaid inadvertently pays you for the crossover claim and the paper claim, you need to adjust the paper claim requesting Medicaid recoup the duplicate payment.

Pharmacy Claims Processing Changes – Effective September 1, 2006

Pharmacies - please forward this message to your software vendors so the appropriate NCPDP fields are sent. A change has been made to address outstanding processing issues that often result in ND Medicaid paying more than what was due or the patient paying more recipient liability than was due.

ND Medicaid has made the following modification to our system:

Field 433-DX (Patient Paid Amount Submitted) is interpreted as the patient responsibility reported by any primary insurance or discount card.

Field 433-DX may only have a value if the claim was submitted to a payer other than Medicaid before it was submitted to Medicaid.

The sum of 433-DX and 431-DV (Other Payer amount Paid) is used to determine the "Bill Amt" for our claims processing (instead of 426-DQ - Usual & Customary).

This modification allows Medicaid to pay an amount not to exceed the total due according to the primary insurance.

Here is an example showing the change:

Pharmacy's usual and customary = $100

Primary insurance allows $90 ($10 co-pay plus $80 payment)

ND Medicaid's reimbursement rate allows $95

Prior process

ND Medicaid recognized $100 billed amount (426-DQ) with $80 primary insurance payment (431-DV)

ND Medicaid paid $15 (Medicaid's allowed of $95 less $80 payment) instead of the $10 patient co-pay that was due

Current process

ND Medicaid adds $80 payment (431-DV) and $10 co-payment (433-DX) for billed amount of $90

ND Medicaid pays $10 since billed amount of $90 is less than allowed of $95

Guidelines for Submission of Paper Claims and Adjustments

Please follow these guidelines to ensure your claims can be scanned and processed in a timely manner. If claims and attachments are not submitted according to these guidelines, they will be returned to the provider.

1. Use only blue or black ink to complete claims or attachments. Make sure the ink is dark enough to be picked up by the scanner. Do not use red ink.
2. Times New Roman font is preferred.
3. All information must be legible, typed (preferably) or printed, and within the boxes. Please make sure information does not touch or cover the lines or writing on a claim.
4. Do not use colored paper or highlighter on claims or attachments.
5. Submit claims and attachments on 8½ X 11 paper. If any item is smaller or larger than this size, you will need to copy it so it is on 8½ X 11 paper.
6. Do not submit carbon copies of claims or attachments.
7. The claim or attachments cannot have any dark smudges or dark print that runs together.
8. Do not place any stickers on the claim.
9. Do not submit two-sided documents.
10. Do not use whiteout on claims.
11. Only one line of service is allowed per detail line on the claim form. Do not bill with two service lines compressed into one detail line.
12. Do not use dashes or slashes.
13. The Revenue Code cannot be greater than three positions. Do not enter a leading zero.
14. When submitting multiple-page claims, you MUST follow these guidelines:

The following fields must match on all pages of a <u>multiple page UB-92:</u>

Statement Covers Period (box 6)
Provider ID (box 51)
Diagnosis codes and principle procedure code

** Special Note regarding Total Charges. Total Charges MUST remain blank on every page except the final page of the claim, where the total for the entire claim must be filled in. Note on the claim "Continued" or "Page 1 of 2", etc.

The following fields must match on all pages of a <u>multiple page HCFA 1500:</u>

Recipients Medicaid ID Number (box 1a)
Recipients Medicaid Name (box 2)
Patient Account Number (box 26)
Provider Name and Number (box 33)

** Special Note regarding Total Charges. Total charges MUST remain blank on every page except the final page of the claim, where the total for the entire claim must be filled in. Note on the claim "Continued" or "Page 1 of 2", etc.

COORDINATED SERVICE PROGRAM (CSP)

Referral Procedures

The Coordinated Services Program (CSP) is an educational program designed to correct the misuse of medical services. A coordinated effort between practitioners and the Medicaid program is necessary to achieve quality care for Coordinated Services recipients.

The Surveillance and Utilization Review (S/UR) staff sends the Coordinated Services Program physician a CSP referral form to use when making a referral to specialists. The form should be used when referring patients, to assure Medicaid payment to the referred specialist and for medications prescribed by the referred physician. This form can be copied for your use. The form must be sent immediately to the S/UR Unit by mail or FAX: 701-328-1544. Same day referrals may be made by telephone at 1-800-755-2604 or 701-328-2321 or by FAX.

All referrals must:

- **Have a start date**
- **Indicate end date or that the referral is ongoing**
- **Be physician specific**
- **Indicate the full name of referred physician (not the clinic name)**

If the Coordinated Services physician is going to be out of the office for an extended period of time, contact the S/UR Unit staff and inform them who will be providing care for the recipient during the absence. The referral form may also be used to report this information. The standby physician should only be providing urgent or emergency services in the absence of the Coordinated Services physician. Routine and on demand services should be referred back to the Coordinated Services physician upon his/her return. Likewise, when a Coordinated Services physician relocates or retires, please notify the S/UR staff so arrangements can be made for a new physician for the recipient. This can be done by telephone or letter. If the recipient is advised by letter, a copy of the recipient's letter to S/UR staff is sufficient.

Medicaid pays for services provided through appropriate referrals but does not pay for referrals that have been initiated retroactively to satisfy patient demands. All referrals must be made by the Coordinated Services physician, not the referred physician, and must be made prior to providing the service. **Unlike the Primary Care Physician (PCP) program the CSP requires referrals to any physician or specialist is required, even if the physician or specialist is located within the same clinic.**

The patient should only be referred to another specialist when medically indicated. **Retroactive referrals are not accepted.** Referrals should not be made on demand by the patient.

Medicaid will pay for tests, therapies, and prescribed medications by the referred physician. **Emergency room visits must meet the criteria for an emergency (as defined in NDAC §75-02-02-12) and as determined by the Department's review team and are not handled through the referral process.**

Claims Procedures

When filing a claim, enter the referred physician in block 17 and 17A on the HCFA form. For electronic claims, the referred physician should be entered in the appropriate block per provider's specific software.

The referred physician's claim must not be filled until the Coordinated Services Physician has made and submitted the referral to the state S/URS Office

OUT-OF-STATE SERVICES

Emergency Out-of-State Transfer - Reminder to Hospitals & Physicians

North Dakota Medicaid requires notification of all emergency transfers to out-of-state facilities within 48 hours of the transfer. The information may be telephoned to Dan L. Johnson at 701-328-4027 or faxed to NDMA at 701-328-1544. This information must include the following:

- Destination and date of transfer,
- Mode of transportation, and
- Discharge summary from the transferring hospital.

ND Administrative Code (NDAC), §75-02-02-13 (3)(a) states, in part: "A referral for emergency care, including related travel expenses, to an out-of-state provider may be made by the primary physician. A determination that the emergency requires out-of-state care may be made at the primary physician's discretion, but is subject to review by the department."

All emergency medical claims, including emergency transportation claims, are subject to post Medicaid review and will be denied if a medical emergency (as defined in NDAC §75-02-02-12) is not demonstrated.

Out-Of-State Referrals – Prior Authorization Requirements

- Out-of-state services at sites more than fifty statute miles from the North Dakota border must be prior authorized. (Out-of-country services are never covered, regardless of distance.)
- The recipient's Primary Care Physician must submit a written request to the Medicaid program for authorization for out-of-state services at least two weeks before scheduling an appointment. Requests must include:
    1) Recipient's name, Medicaid ID number, and date of birth,
    2) Diagnosis,
    3) Medical information supporting the need for out-of-state services,
    4) A written second opinion from an appropriate in-state board certified specialist, following a current (within 3 months) examination, which substantiates the medical need for out-of-state care,
    5) The physician and facility being referred to, and
    6) Assurance that the service is not available in North Dakota.
- The Medicaid office determines if the referral meets state requirements and approves or denies the request in writing. A copy of the determination is sent to the primary physician, out-of-state provider(s), recipient, and county social service office.
- Emergency out-of-state services are allowable at the in-state physician's discretion but are subject to Medicaid review and denial of claims. The transferring facility must notify ND Medicaid within 48 hours of the transfer. Documentation must include: destination and date of transfer, mode of transportation and discharge summary. If the trip was less than 50 miles, the facility must verify why air ambulance, rather than ground ambulance was used.
- Claims from out-of-state providers will not be paid without written prior authorization.
- Recipients of MCO's are not subject to prior authorization requirements, but are subject to prior authorization requirements as established by the MCO's.
- The recipient's County Social Service Office is responsible for authorizing the recipient with arrangements for travel, lodging, and meals.

PHARMACY

Medications Requiring Prior Authorization – (Last Modified 5-15-06)

LESS / NON-SEDATING ANTI-HISTAMINES (INCLUDING D COMBINATIONS)

BRAND NAME	GENERIC NAME	EFFECTIVE DATE
Allegra	fexofenadine	3/02/04
Clarinex	desloratadine	3/02/04
Zyrtec	cetirizine	3/02/04

PROTON PUMP INHIBITORS

BRAND NAME	GENERIC NAME	EFFECTIVE DATE
Aciphex	rabeprazole	3/02/04
Nexium	esomeprazole	3/02/04
Prevacid	lansoprazole	3/02/04
Prilosec	omeprazole	3/02/04
Protonix	pantoprazole	3/02/04
Omeprazole		3/02/04

BRAND NAME MEDICALLY NECESSARY (DAW=1) DRUGS

Effective Date	4/13/05

BRAND NAME NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS) AND CYCLOOXYGENASE-2 INHIBITORS (COX-IIS)

List only includes medications for which generics are not available

BRAND NAME	GENERIC NAME	EFFECTIVE DATE
Arthrotec	diclofenac/misoprostol	4/19/05
Celebrex	celecoxib	4/19/05
Mobic	meloxicam	4/19/05
Ponstel	mefenamic acid	4/19/05

ANGIOTENSIN CONVERTING ENZYME INHIBITORS (ACE-I) (INCLUDING HCT COMBINATIONS)

List only includes medications for which generics are not available

BRAND NAME	GENERIC NAME	EFFECTIVE DATE
Aceon	perindopril	5/22/05
Mavik	trandolapril	5/22/05
Uniretic	moexipril/hctz	5/22/05

ANGIOTENSIN II RECEPTOR BLOCKERS (INCLUDING HCT COMBINATIONS)

BRAND NAME	GENERIC NAME	EFFECTIVE DATE
Atacand	candesartan	7/15/05
Avapro	irbesartan	7/15/05
Benicar	olmesarta	7/15/05
Cozaar	losartan	7/15/05
Diovan	valsartan	7/15/05
Micardis	telmisartan	7/15/05
Teveten	eprosartan	7/15/05

SEDATIVE/HYPNOTIC AGENTS

BRAND NAME	GENERIC NAME	EFFECTIVE DATE
Ambien CR	zolpidem	6/01/06
Lunesta	eszopiclone	6/01/06
Sonata	zaleplon	6/01/06
Rozerem	ramelteon	6/01/06

INDIVIDUAL AGENTS

BRAND NAME	GENERIC NAME	EFFECTIVE DATE
Zanaflex caps	tizanidine	8/09/05
Xenical	orlistat	9/01/99
Revatio	sildenafil	6/06/05
Acto*plus* met	pioglitazone/metformin	2/13/06
Growth Hormone Products		6/01/06
IGF-1 Products		6/01/06

Spacers For Asthma Inhalers

North Dakota Medicaid covers Optichamber® / Optihaler® inhaler assist devices. Pharmacies need a prescription to bill ND Medicaid.

Medicaid will not cover Aerochamber® since Optichamber® is very similar and much less expensive.

FREQUENTLY ASKED QUESTIONS ABOUT THE NATIONAL PROVIDER IDENTIFIER (NPI)

- **What is the National Provider Identifier (NPI)?**

Currently, North Dakota Medicaid assigns identification numbers (Medicaid Provider Numbers) to providers, individuals, groups, and organizations that provide medical or other health services or supplies. As a result, providers who do business with multiple states have multiple identification numbers. The National Provider Identifier (NPI) is a unique identification number for health care providers that will be used by all health plans nationwide.

- **Origination of the NPI**

It is a provision of the Administrative Simplification portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- **Who must comply?**

Entities covered by HIPAA using electronic transactions must comply (examples: providers, clearinghouses, payers).

- **Are paper transactions included in the mandate?**

No. Paper transactions are not considered electronic transactions. However, the CMS1500 and UB forms will be changing to accommodate NPI numbers among other fields.

- **What is the compliance date?**

CMS has mandated that beginning May 23, 2007, all health care agencies must be able to accept NPI numbers, and all health care providers sending electronic transactions must use their NPI numbers.

- **What will the NPI look like?**

The NPI will be a 10 digit numeric field that will include one check digit in the tenth position to ensure accuracy. The NPI will contain **no** imbedded intelligence. In other words, a provider's state, region, specialty, or other information, will not be able to be determined directly from their NPI.

- **Will a provider's NPI ever change?**

In most cases, no. If a health care provider (for example, a physician) dies, his/her NPI will be deactivated. If a provider goes out of business, the NPI will also be deactivated. The deactivated NPI will never be issued to another health care provider. If a provider moves from one state to another, the NPI number will stay the same.

- **Does the NPI replace the Tax Identification Number (TIN)?**

No. The NPI is not designed to replace the provider's TIN.

- **How do I get an NPI?**

There are 3 ways to apply:

1. By using the web-based process at https://nppes.cms.hhs.gov/NPPES/Welcome.do
2. By filling out a paper NPI Application/Update form and mailing it to the Enumerator. The form is available at: http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIapplication.pdf
3. A Provider's NPI application information may be submitted on their behalf by an organization in an electronic file format to the National Plan and Provider Enumeration System (NPPES). This process is known as Electronic File Interchange (EFI) for bulk enumeration. For an organization to do this, they must have the provider's permission.

- **NPI Tip:**

When applying for an NPI, the Centers for Medicaid and Medicare Services (CMS) urges entities to include their legacy identifiers, not only for Medicare but also for all payers. If reporting a Medicaid number, include the associated state name. This information will aid in the transition to the NPI.

- **What is a subpart?**

An entity that is part of a covered organizational provider is a subpart. These entities may function independently of the covered organization and may have their own billing numbers, licensure, and or physical location (example: clinics, departments, pharmacies, and nursing homes). Durable Medical Equipment (DME) suppliers are required to obtain an NPI for every location. The only exception to this requirement is the situation in which the DME supplier is a sole proprietor. A sole proprietor is eligible for only one NPI regardless of the number of locations the supplier may have.

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We're on the Web! See us at:
http://www.nd.gov/humanservices/services/medicalserv/medicaid

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DIVISION OF MEDICAL SERVICES
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- ☐ Billing clerks
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- ☐ Other Appropriate Medical Personnel

Please make copies as needed.

Frequently Asked Questions About the NPI -Continued

- **What will happen if I bill using my Medicaid number?**

After May 23, 2007, any electronic claim not containing a provider's NPI number will be denied, and the provider will have to re-bill using their NPI number.

- **What if I have more than one Medicaid Number?**

You will only receive 1 NPI number, and that is the number you will use when billing any health plan. Individual providers with an "entity type code" of 1 will be issued one NPI that will be a permanent identifier assigned for life, unless circumstances justify deactivation. Heath care providers that are organizations will be issued an "entity type code" of 2. Many subparts of an organization are eligible to be assigned their own NPI number.

- **When I do a Prior Authorization, do I use my NPI number or the State Medicaid number?**

After May 23, 2007, you will be required to use your NPI number.

- **When I use the Medifax System, do I use my Medicaid Number or an NPI number?**

After May 23, 2007, you will be required to use your NPI number if you are a provider that is required to obtain an NPI number.

- **How can I learn more about NPI?**

The Medicaid Bulletins, your remittance advice, and the DHS Web site: www.nd.gov/humanservices/info/provider-npi.html. This federal Web site also contains useful information: http://www.cms.hhs.gov/NationalProvIdentStand

The North Dakota Department of Human Services and the state Information Technology Department are co-hosting a series of informational meetings beginning August 9, 2006 for medical service providers and their associations who will be impacted by the new federal NPI number.

The meetings will be held the second Wednesday of every month through December 13, from 1 to 2:30 p.m., in the Judicial Wing of the State Capitol, second floor, AV Room. Providers outside of the Bismarck area should e-mail the help desk at mailto:dhsnpihelpdesk@ nd.gov for dial-up information that will enable them to participate. Providers are encouraged to e-mail questions to the help desk at least 24 hours in advance.